American Society of Anesthesiologists™

Timely Topics
Payment and Practice Management

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Dangling Modifiers: Modifiers You Need to Know Even if You Don't Need to Use

Wikipedia defines a grammatical modifier as an optional element in phrase or clause that can change the meaning of other elements within the sentence. Wikipedia defines a qualifier as a required element within a sentence without which the sentence lacks meaning.[i] In medical coding, modifiers are used to both *modify and qualify* the procedure or service defined by the reported CPT® code. Some modifiers are informational, and others will impact payment. Examples that are familiar to anesthesia and pain medicine include:

AA: Anesthesia Services performed personally by the anesthesiologist
This modifier determines that 100% of the allowed amount for the anesthesia care is to be paid to the anesthesiologist.

59: Distinct procedural service
This modifier clarifies that the associated service is eligible for payment separate from that for another service performed during the same patient encounter.

QS: Monitored anesthesia care service
This modifier does not impact payment but serves to inform the payer that the anesthesia care was MAC rather than general or regional.

In sentence structure, sometimes a modifier is left dangling. Looking again to Wikipedia, a dangling modifier is one that could unintentionally be linked to a part of the sentence other than what was intended – or to nothing at all. [ii]

Medical coding now includes modifiers that could be seen as "dangling" in that they are valid and active, but their use is not required at this time. With all the changes we see each year with regular coding/billing updates and with newer additional requirements (think the Merit-based Incentive Payment System (MIPS)), it may seem unnecessarily burdensome to become informed about modifiers that you need to know –but not use. However, in order to stay nimble and to be able to position your practice for future requirements and situations, you need to stay up-do-date on these modifiers.

Specific Modifiers for Distinct Procedural Services

Back in 2015, the Centers for Medicare & Medicaid Services (CMS) released Medlearn Matters® Number 8863 to introduce and explain the following new modifiers which have been referred to as X{EPSU} and intended to provide more information in scenarios where modifier 59 would be appropriate:

XE: Separate Encounter
A Service That Is Distinct Because It Occurred During A Separate Encounter

XS: Separate Structure
A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure

XP: Separate Practitioner
A Service That Is Distinct Because It Was Performed By A Different Practitioner

XU: Unusual Non-Overlapping Service
The Use OF A Service That Is Distinct Because It Does Not Overlap Usual Components OF the Main Service.

These modifiers are to be used instead of modifier 59 and not in conjunction with it. Later that same year, the Medlearn Matters article was revised to let us know that *"additional guidance and education on the appropriate use of the new X modifiers will be introduced in a gradual, controlled fashion"* and that Modifier 59 could still be used as it has been. That additional guidance is still pending.

The Quality Payment Program (QPP) as implemented via the Medicare Access and CHIP Reauthorization Act (MACRA) includes attribution of costs of care to the clinicians who provide care to Medicare beneficiaries. This includes the creation of modifiers to classify the relationship between the beneficiary and the provider(s) of care. Like the anesthesia concurrency modifiers, these modifiers for Patient Relationship Codes/Categories are part of the Healthcare Common Procedural Coding System (HCPCS) code set which is maintained by CMS. These modifiers became effective January 1, 2018 but their use is voluntary at this time.

X1: Continuous/Broad Services
To be used by clinicians who provide a patient's principal care on an ongoing basis.

X2: Continuous/Focused Services
To be used by clinicians providing long term care to a patient to treat a chronic disease or condition.

X3: Episodic/Broad Services
Reported by clinicians who provide comprehensive care to the patient for a limited and defined period of time.

X4: Episodic/Focused Services
Reported by a specialty focused clinician who provides care that is time-limited.

X5: Only as Ordered by Another Clinician
This modifier is used by those who only provides care that has been ordered by another clinician.

Anesthesia and treatment of acute post-operative pain may fall under modifier X4; ongoing treatment of chronic pain may fall under modifier X2.

Since attribution of costs will become more important as the Cost component of MIPS takes on a greater role in determining eligible clinicians' MIPS scores and as Alternative Payment Models are designed, knowing these modifiers and tracking how they could be used for the services your practice provides – even if only for internal purposes - could help you and your practices be in a better position for future years in the QPP. Further, keep in mind that at some point, their use may become required.
CMS resources to assist you are available at:

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Patient-Relationship-Categories-and-Codes-slides-2-21-18.pdf

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Patient-Relationship-Categories-and-Codes-webinar-FAQ.PDF

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[i] https://en.wikipedia.org/wiki/Grammatical_modifier

[ii] https://en.wikipedia.org/wiki/Dangling_modifier